The Maluhia Project: Home Health Care for the Uninsured

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This is a report of preliminary findings of The Maluhia Project: Home Health Care for the Uninsured based on its first 12 months of experience in providing services to clients from September 1989 to August 1990. This Project is now in its third year. This report will initially discuss the rationale for Hawaii's participation in this 5-state national demonstration project. It will cover the basic components of the Hawaii Project and its relative impact followed by a brief description of the clients enrolled. A major component of this program is case management. Given the variety of previous programs that have been referred to as case-management services, a comparison has been provided to note significant differences in approaches and target groups between the Maluhia Project and other existing programs. Finally, this report discusses a number of implementation and public policy issues which have emerged and require further discussion. We hope that as a result of this preliminary report from our first 12 months of operation, it will be possible to inform the medical community of the needs faced by this public health problem that has been previously not addressed.

Background

Nationally, the medically uninsured have dramatically increased from about 12.6% in 1977 (or 26.6 million) to 17.5% (or 37 million) in 1987. This upward change represents a major reversal of the steady downward trend immediately after World War II[1]. Swartz has noted that besides the reversal to post-world war public health trends, there are 3 other reasons why national policy-makers are becoming increasingly concerned about the growth of the medically uninsured.

First, when the uninsured seek medical care and cannot pay for services rendered, health care providers cannot find other sources of revenue to pay for their care. In April 1990, Stan Snodgrass, the former chief executive officer of the Healthcare Association of Hawaii remarked that Hawaii's hospitals had incurred more than $90 million in bad debts in 1989[2]. The significance of this was that it was attributed mainly to the uninsured who are unable to pay their bills. The continuation of this problem might eventually result in the bankruptcy of one or more of our major health care institutions. Such a crisis represents a cost that all of Hawaii's citizens must bear.

Second, there is concern that this cohort does not have sufficient access to medical care. It is generally assumed that easy access to medical care will promote its use, and in turn, this will result in a healthier population. Although there are unanswered questions regarding what is optimal medical care and whether medical care per se is the most cost-effective means to a healthier population, there is evidence that uninsured people repeatedly have been shown to have less access to medical care. There is a sense that those not receiving medical attention are often less healthy. The economic and social costs of this trend towards the growth of an unhealthy population are therefore enormous.

Finally, the recent crisis with HIV/AIDS has brought forth the concerns regarding special financial assistance for AIDS patients lest we exceed the fiscal viability of hospitals and cities throughout the U.S. Many advocates for these patients have argued for the use of the Medicare Fund, just as was done for end-stage renal disease patients in 1972. However, it will be difficult to justify such a recommendation without adequately addressing the question of equity for the medically uninsured.

As a response to this concern for the medically uninsured, Congress enacted and appropriated funds for the Health Care Services in the Home Act in 1987. This Act provided funds to 5 states: North and South Carolina, Mississippi, Utah and Hawaii. The purpose of the Act is to demonstrate that avoidance of lengthy stays in hospitals and other institutions for individuals at-risk is possible if a multidisciplinary team of health professionals manages the delivery of home care in which comprehensive and continuous skilled medical and related health services are combined with other long-term care services. The Act hopes to demonstrate the impact that a multidisciplinary team can have on the effectiveness, efficiency, quality and acceptability of the home health program. The Act is directed towards state-initiated programs only. Given the limited time such demonstration projects are granted, in general, we hope that state-sponsorship in addition will assure a

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commitment to a longer term, provided that each of the 5 state projects are deemed cost effective.

Based on the national guidelines, individuals to be targeted for assistance are to have several characteristics in common: (a) Low income; (b) a very high probability for extensive and repeated hospital and institutional stays due to health problems which could have been managed otherwise in a home setting; (c) the desire to receive their care at home and (d) the inability otherwise to purchase the needed health services. The recipient can be any age, although at least 25% are to be over age 65.

Funding was allocated to state agencies to assess the health needs of the "gap group" over a 3-year period beginning with the federal fiscal year 1989. Based on the Act of 1987, federal contributions were 75% in the first year, 65% in the second and 55% in the last. State matching funds make up the difference. Hawaii's program has been based on a $1.3 million budget in each of its 3 years according to the aforementioned federal/state formula. This national demonstration has just be extended for another 3 years up to the Fall of 1994.

Basic components of the Hawaii project

The Hawaii Project is sponsored by the Hawaii State Department of Health (DoH). It is situated at Maluhia — a long-term care health center in Honolulu. It is known as The Maluhia Project: Home Health Care for the Uninsured. As with the national program, the Maluhia Project's original application targeted the uninsured who were frequent users of hospitals and emergency rooms. Since then, the Project has expanded its services to the underinsured as well. The project began in October 1988 with its first year devoted entirely to planning and development. This report discusses the second year of the project or the first year of delivery of clinical services.

Services:

Services provided by the program include screening, information and referral, comprehensive assessment, care plan development, home health-care services, case management and financial coverage by the Project's funds. A direct service, professionally-led, interdisciplinary team manages the care provided to each client enrolled in this program. A core team composed of a physician, nurse and social worker, augmented by paraprofessional home health aides, work to keep clients at home. Occupational and physical therapists are involved as needed. Education and training of patient and family along with family support are also integral parts of the total services rendered.

One of the key characteristics of this program is its control over its own service dollars and the fact that home health services are not limited to the Medicare definition of skilled home health care. The Project's definition of skilled care includes (1) observation and assessment of the clients' condition, (2) and of medication compliance on a long-term basis, (3) extended professional services to clients at-risk for rehospitalization or nursing home placement and (4) counseling and family support. In addition, unlike a typical home health-care service, which is driven by health care insurance dollars, clients enrolled under this program continue to be case-managed even when "skilled" home health-care services as defined by Medicare are no longer required. Continuity in case management provides an opportunity to monitor the client's condition to prevent reoccurrence of acute episodes as much as possible. This project emphasizes the importance of mutual participation by client and caregiver with the project's staff. Self-care skills needed in the maintenance of the client's health are taught to both the client and the caregiver.

Using funds from federal and state sources, this project is able to cover the cost of the comprehensive assessment, care plan development, nursing, social work, occupational and physical therapists, physician services, durable medical equipment and other related expenses such as health-related transportation services. If medication is required, the client would be expected to share partly in the cost. The Project is aimed at serving those in need of home health care but who do not have the ability to pay for it.

In-hospital, institutional long-term care and emergency room services are not covered by the Project. Likewise, personal care not related to a skilled home health-care service is also excluded, as are personal care supplies (eg, diapers, toiletries), housekeeping, chore services, food supplements or prepared food and dental services. On occasion, the Project is able to identify appropriate clinical usage for its funds that are not part of its usual list of approved services. In any event, these additional services are not reimbursable unless they are preauthorized by the Project's staff.

Strategies:

The Hawaii Project utilized 3 strategies in the delivery of its services on Oahu during the 2nd year. These strategies, or service delivery methodologies, were aimed at developing recommendations regarding the most cost-effective means of delivering services. Essentially, the service delivery methods varied in terms of the degree to which other home health-care agencies were contracted to provide direct home health-care and/or case-management services. Use of contract services was a means to limit the necessity of hiring a full complement of health professionals for a short-term and to increase the responsiveness of the Project. This approach also encouraged the participation of other existing home health-care agencies and reduced the cost of servicing outlying areas on Oahu.

The 3 approaches involved either the full delegation for both home health care and case management services, the partial delegation of only home health care services to agencies with case management provided by the Project, or full service provision by the Maluhia Project within West Honolulu.

At the time of this assessment, modifications have been made to the target areas and the designated agencies that provide for services. Designated agencies are now providing full delegation for home health care and clinical case management outside of Maluhia's primary service area (eg Moanalua to University).

All cases continue to enter through a single point of entry. All cases are referred initially to the Project for eligibility determination. Cases have been referred from a number of

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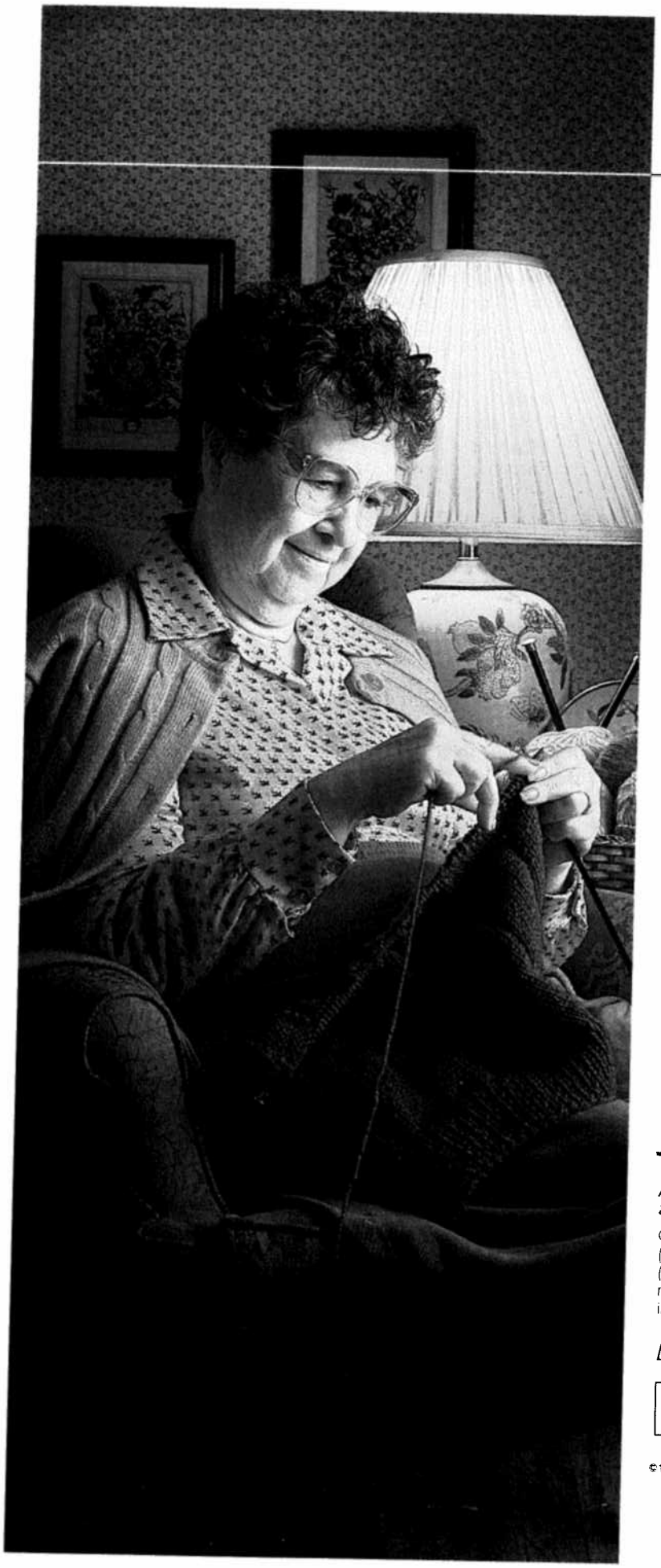

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sources but primarily from hospitals, home health-care agencies and community-based case-management programs.

Eligibility requirements and alterations

Because The Maluhia Project is Hawaii's first program directed specifically at the medically uninsured, there has been relatively little previous data to rely on for direction. As a consequence, the Project has experienced a need to modify its eligibility criteria as a means of identifying clients for the program and to meet the needs of Hawaii's particular gap group appropriately.

Initially, the Project was limited by a fairly restrictive definition of "skilled home health-care" closely aligned to the Medicare regulations. In addition, the target area was limited to 3 regions on Oahu and to those persons whose sources of income did not exceed 150% of the federal poverty standards for Hawaii. Over time, the Project has revised its eligibility criteria to meet the unique needs of Hawaii and to encourage more referrals. Figure 1 lists the revised eligibility criteria for the Project based on the experiences of the Project's first service year. Besides the annual adjustment to the thresholds of the federal poverty guidelines, the Project may modify the criteria for eligibility, depending on other factors.

FIGURE 1
Eligibility Criteria

1. Client resides on Oahu.
2. Client is 18 years or older.
3. Client does not have home health insurance benefits or has been denied coverage or requires uncovered services.
4. Family income does not exceed 300% of Federal Income Poverty Guidelines for Hawaii as shown: (Feb. 1991)

Size of Family	Monthly Gross Income
1	$1,902
2	$2,552
3	$3,202
4	$3,852

Add $615 for each additional family member.

5. Family savings (liquid assets) limited to $4,000 per person; does not include home.
6. Client is at risk for prolonged or recurrent hospitalization or institutionalization, as demonstrated by one of the following:
   a. Long length of stays in hospital or nursing home
   b. frequent readmissions to hospitals (2 or more times a year for any problem)
   c. frequent emergency room visits (2 or more times a year for any problem)
   d. medically or socially complex health condition
   e. vulnerable client/families in need of coordinated medical and social services
   f. potential nursing home placement
7. Client requires skilled services.
   a. Case Management:
      • coordination, collaboration and monitoring of home health and other related services
   b. Direct health services in the home:
      • skilled nursing
      • social work
      • physical therapy
      • occupational therapy
      • speech/language therapy
      • nutritional counseling
      • teaching and counseling
      • family support
      • home health aide
8. Client/family/primary caregiver and physician are willing to participate in a managed system of care, recognizing limited service resources.

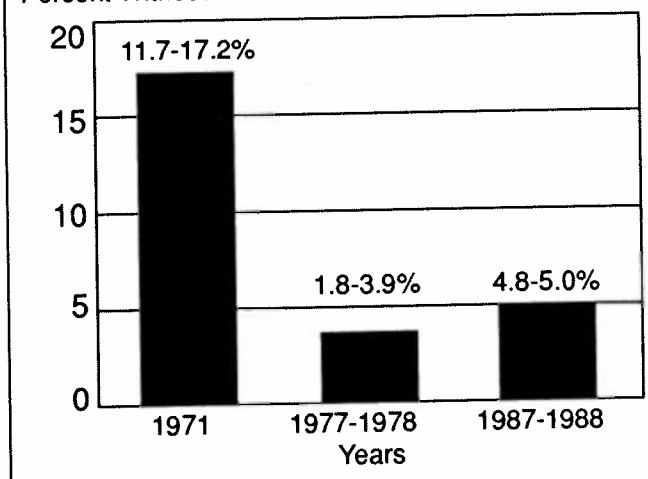
At least 2 major factors have had a significant impact on finding cases. First, Hawaii has a relatively small proportion of its population designated as medically uninsured. As a result of Hawaii's Pre-paid Health Care Act of 1974, most employers provide health insurance coverage for those working 20 hours or more a week. Therefore, the number of medically uninsured dropped from a high of 17.2% of the population in 1971 to a low of 1.8% in 1977-1978. Since then, records indicate that Hawaii's uninsured population is again growing. Although some have estimated that it represents only 3% today[3], most consider a 5 to 7% estimate (ie 60,000 to 84,000 in 1990) more accurate. When the estimate is limited further by targeting only the uninsured on Oahu who are in need of home-health case-management services, the difficulty in locating eligible clients becomes apparent.

A second factor that necessitated adjusting the Project's eligibility criteria after the first half of the first year was the liberalization of the State's Medicaid policies in late 1989. During that time, Hawaii's Medicaid program increased its eligibility limit from 62.5% of the federal poverty guideline to 100% for the elderly and the disabled. In the instance of families with dependent children or of poverty level beginning in January 1990, the Medicaid program has also liberalized its enrollment by its repeal of the ruling on requiring financial responsibility by alien sponsors. As a result, indigent alien applicants for Medicaid are no longer disqualified as a result of their sponsor's above-average financial status.

Sources of referral

During the course of the1989-1990 fiscal year, there were 198 referrals from numerous sources. Among these sources,

FIGURE 2
Proportion of Hawaii population without health care insurance

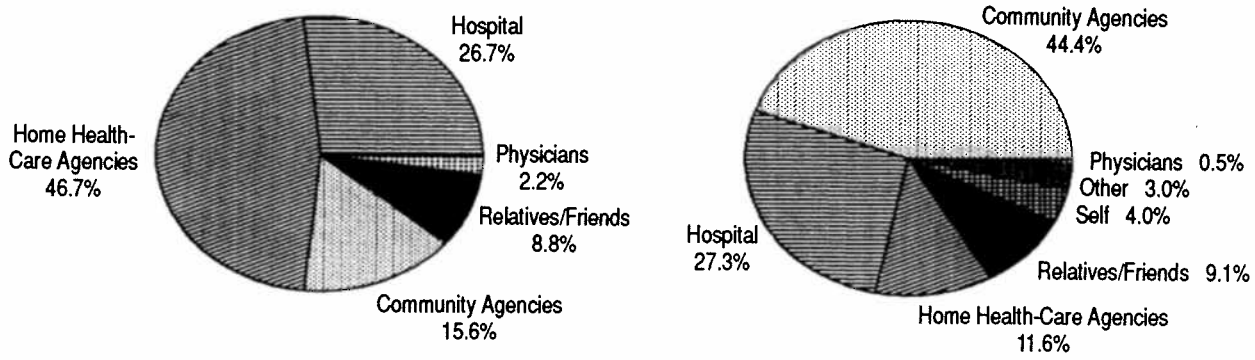


Source: Hawaii Department of Health

community-based agencies (eg case-management programs, social service agencies for the elderly, public health nursing) referred the most cases (44.4%). Others that also contributed were hospitals (27.3%), home health-care agencies (11.6%) and relatives and friends directly (9.1%). Physicians were not significantly involved with referrals (0.5%); this may be due to a lack of knowledge about the Project or what the Project's services cover.

According to Figure 3, the pie chart representing only the enrolled clients indicates that there was little correlation between the proportion referred and the proportion enrolled from various sources. Most notably, home-health-care agencies (46.75%) were the Project's most reliable and appropriate source of referral, probably because they best understood the

FIGURE 3
Comparison of Referral Sources
Total referred cases vs. enrolled cases — September 1989 to August 1990



Total referred cases = 198 Enrolled cases = 45

FIGURE 4
Case Examples from the Maluhia Project Files

This is a 43-year-old part-Hawaiian unemployed laborer, married and living in his mother-in-law's home with his wife and three younger children. His four older children visit frequently. He was referred to the Project by a hospital social worker since he had no health insurance and was in need of home care for wound management and home IV antibiotic therapy. His diagnoses are infection in his left heel, diabetes mellitus type II, diabetes nephropathy with proteinuria.

He was first diagnosed as a diabetic in 1987 when he was hospitalized for cellulitus secondary to an infected right heel wound. He was placed on Micronase with no apparent follow-up for his diabetic condition. Due to the lack of sensation, he was initially unaware of a punctured left heel wound in 1989. He was treated as an out-patient with Augmentin 250g po tid for about 3 weeks, then hospitalized on the wife's insistence.

Home health-care and case-management services have been involved with wound care, IV antibiotic procedures, diabetic education including glucose self-monitoring. Case-management monitors his diabetic condition.

* * *

This is a 55-year-old Filipino man who was a former self-employed television repairman prior to his right CVA, left hand dominance. He lives with his second wife and their 2 children, ages 18 months and 3 years. He was assessed by the Project about 4 days following hospital discharge. He has no medical coverage. His diagnoses are right paraventricular cerebral infarction, hypertension, diabetes mellitus type II insulin dependent, abnormal chest x-ray scar from an old tuberculosis and a history of Bell's Palsy. He has left hemiparesis. He is able to feed himself but swallows with difficulty. He wears an eye patch to obliterate double vision and dizziness. He has been highly motivated towards rehabilitation but faces numerous financial and family relationship problems. The Project monitors his hypertension and diabetic status in coordination with his physician and has taught him glucose self-monitoring. The Project nurses coordinate occupational and physical therapy services. The Project's social worker has been providing family financial counseling, access to legal counseling and assistance in family problem-solving.

* * *

This is a 53-year-old woman, owner of a plant nursery. She is a part-Hawaiian woman who has been separated from her husband for approximately 10 years of her 30-year marriage. She was referred to the Project by a public case-management agency that had received the case from an HMO hospital which does not include physical therapy services in its home-care benefit package. The client is diagnosed as having multiple CVAs hypertension and diabetes mellitus type II. The CVA has left her with self-care deficits, G-tube feeding, speech problems, and dysarthria. In addition, she has higher functional deficits such as in food preparation, shopping, housekeeping because of her difficulties with mobility. Abstract and mental processing skills have also been affected. The family's home poses difficulties for her, given the need to negotiate 20 steps to reach the front door.

Her family support system is excellent due to her husband's and children's positive attitudes in encouraging her to reach her maximum potential for independent living. The Project's services have included educating the client and her family about stroke, hypertension and diabetes. It has also included close collaboration with the physician regarding her medication compliance and glucose-monitoring as well as OT and PT progress. The client is now attending adult day health-care to maintain her mobility skills and to provide socialization. Speech therapy assessment of the client's dysarthria and dysphagia will be needed when there are some oral movements.

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eligibility criteria. Hospitals (26.7%), community agencies (15.6%), relatives/ friends (8.8%) and primary care physicians (2.2%) were responsible for the remaining enrollees. Self-referrals based on information obtained from newspaper articles have not proved to be effective so far. The Project also found that among the various hospitals, most of the appropriate referrals came from only 3 hospitals. Other facilities with similar types of patients did not refer as many cases, indicating a lack of sufficient knowledge and understanding of the Project. Clearly outreach and marketing are required to increase referrals from all provider groups and to reduce inappropriate referrals. Since outreach has been increased and eligibility further clarified, referrals have since become more appropriate.

Characterizations of accepted clients

Generally speaking, Hawaii's medically uninsured tend to be the near-poor unemployed, those who work fewer than 20 hours a week, those employed in family businesses, seasonal agricultural workers, adult dependents of low-income workers, some government workers ineligible for public employee plans, some salespersons working on commission and many children[5]. Figure 4 provides 3 case examples to illustrate some of the types of clients that are enrolled in the Project.

Demographic statistics

From September 1989 to August 1990, there were 198 referrals to the Project. Of these, 45 were admitted; 9 were discharged due to death, relocation outside Oahu or placement in nursing homes, leaving 36 that were being managed. Of the 36, 16 were at the ICF-level of care and 8 at the SNF-level. One-third of the clients were immigrants. Most were at the above-designated levels upon entry and have since improved in their ability to function. All cases required case-management services. Services included skilled nursing assistance, training of patient and caregiver and linkage with other resources in the community. The most common problems included noncompliance, patient-physician communication difficulties and patient/family's lack of basic knowledge about the patient's medical and dysfunctional status. Social work services centered on financial issues such as money management, the search for entitlements and grants for needed supplementary services, and counseling.

As noted in Figure 5, the majority of the clients (60%) were over 60-years of age. There were approximately 31.3% between 40- and 59-years old and very few between 18-to-39 years old (6.7%).

In Figure 6, the ethnic distribution of the Project's caseload is illustrated. Based on the information provided, the Filipino group comprised 33.3 percent of the clients. Other significantly large groups included the Japanese (15.7%), Hawaiians (13.3%), Caucasians (11.1%) and the Chinese (11.1%). The remaining groups included the Samoans (6.7%), Portuguese (4.4%) and all others (4.4%).

An analysis of data on client origin in Figure 7 reveals that 40% were from Honolulu proper. The second most significant source was the Waianae coast/Ewa Plains area which account-

FIGURE 5
THE MALUHIA PROJECT
Age Distribution of 45 Clients

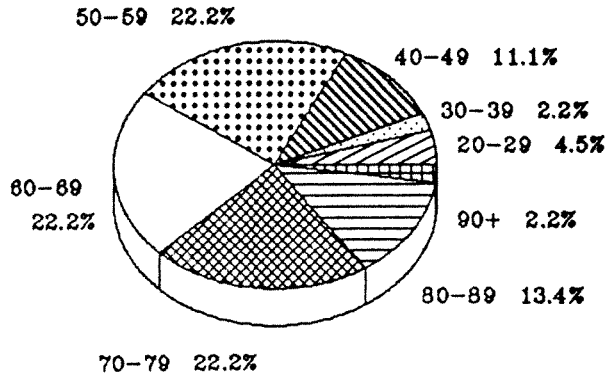

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FIGURE 6
THE MALUHIA PROJECT
Ethnic Distribution of 45 Clients

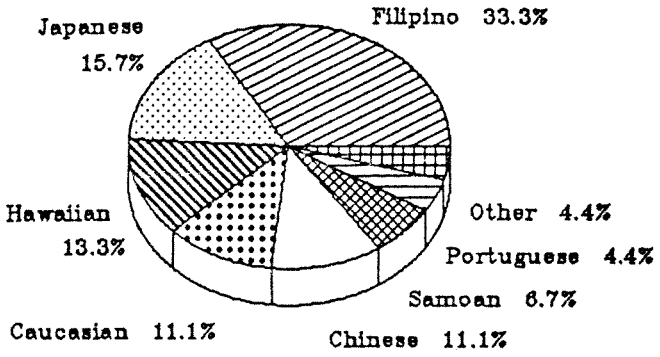

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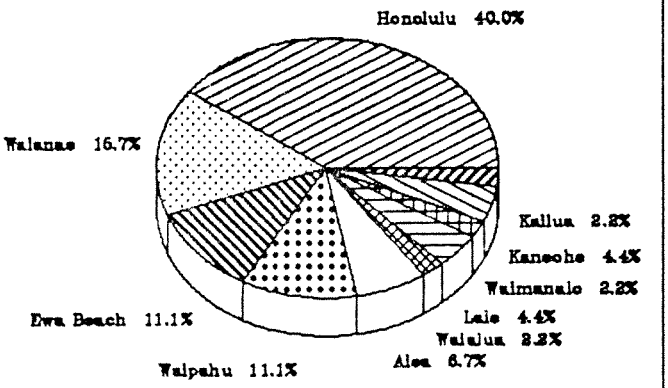
FIGURE 7
THE MALUHIA PROJECT
45 Clients' Origin on Oahu



Date: August 1990

ed for 26.4% of the clients. The Leeward area (15.8%), North Shore (7.9%) and the Windward coast (7.9%) made up the remainder.

Medical diagnoses

Figure 8 portrays the prevalence of several medical diagnoses among the 45 clients enrolled. Based on the data obtained, diabetes, hypertension and heart problems were present about 33% of the time. Respiratory problems (17%) and strokes (20%) were the next most prevalent problems, followed by eye-ear problems, arthritis, cancer and infections/wounds at about 13.3%. The least prevalent categories included kidney and liver diseases at 6.7%; all others were 17%. The latter included a mix of Alzheimer's disease, orthopedic problems, GI problems, Parkinson's, nonmalignant tumors and encephalopathy. Ninety-nine different diagnoses were recorded among the 45 enrolled clients. The clients averaged 2.2 diagnoses each.

Insurance Coverage

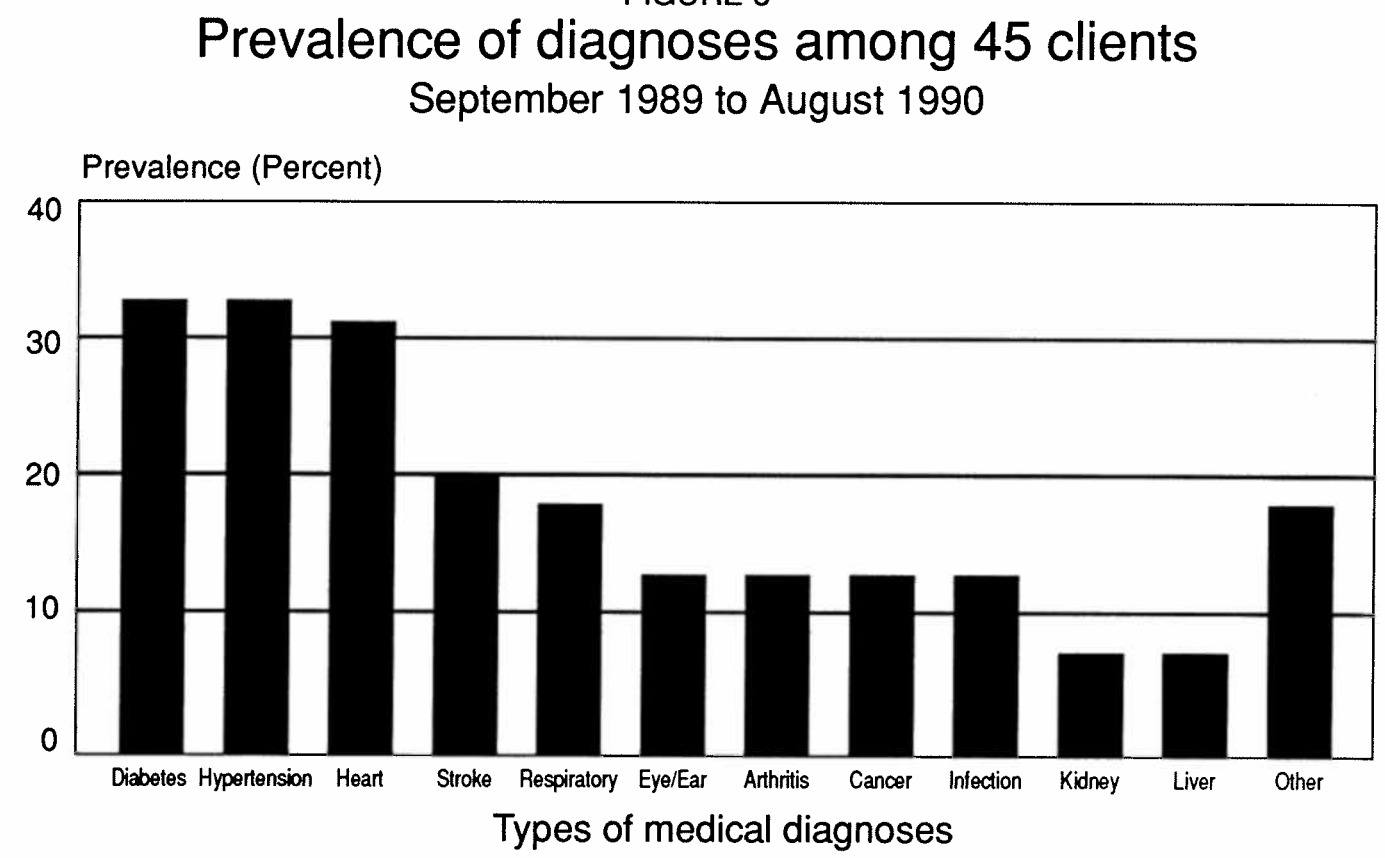
One of the most remarkable findings to date has been the relatively small number of clients who were without any insurance at all. At the time of this analysis, 9 clients were actually uninsured. Nevertheless, this small proportion at the end of 12 months is not indicative of all clients at the time of enrollment. Given the role of the case managers as brokers and coordinators of services, some of the clients who initially enrolled without insurance were subsequently linked to existing programs, namely Medicaid and the State Health Insurance Program (SHIP). However, most of the clients had very limited coverage by one or more health insurance programs.

Given their physical status, those with limited health insurance coverage were underinsured. The Kaiser Permanente Medical Care Plan, for example, does not cover home-based occupational, physical and/or speech therapy or medical social work services. Medicare's home-health benefits require that the patient be homebound and HMSA has a 15O-visit limit per year. In addition, no medical insurance plan covers case management as a skilled home-health-care service. Over time, it is anticipated that inadequate health coverage will become an increasingly serious issue.

Outcome

Although it is still too early to assess the full impact of the Project's services, preliminary evidence suggests that it is effective in reducing rehospitalization and excessive emergency room visits. As a rough estimate, 50 clients enrolled between September 1989 and 1990 were evaluated as to their use of hospital and emergency room services during the 12 month period prior to August 1990. There were 72 hospitalizations (144%) and 31 emergency-room visits for a 62% use rate. By comparison, the 12-month period ending in Septem-

FIGURE 8



Total Number of Dx = 99
Average Number of Dx/Patient = 2.2

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ber 1990 revealed only 21 hospital admission (42%) and 14 emergency room visits (28%) by this particular group.

The differences from other case management services

As noted above, the key components of the Maluhia Project were its combined use of (a) home health care and (b) case-management services on a (c) long-term basis using its (d) resources of federal and state funds and (e) based on assessment and monitoring by a multidisciplinary team. Control of financial resources by the multidisciplinary team permitted the delivery of services on a timely basis. Long-term case management provided the assurance that frail clients who improved enough to be on their own were not abandoned. Monitoring continued for at least 3 months.

Figure 9 is a comparison chart of the major community case-management services on Oahu in terms of the nature of their assessment capabilities, the availability of home-health care, personal care and case-management services. As noted in the chart, the Maluhia Project is unique in the multidisciplinary nature of its assessment. It is also unique, given its ability to provide professional home-health care and long-term case-management services.

Identification of issues

During the course of this Project, there have been many concerns and issues raised. The issues identified are not necessarily new or unique. Nevertheless, these concerns point to what is common to all community-based, long-term care services as they have attempted to provide quality and cost-effective care in settings that are difficult to manage or to assure compliance from clients.

The Hawaii Project maintained that an important criterion for enrollment in the Project was the full cooperation of the client, family caregivers and the physician. In time, however, it became quite obvious to the Project staff that many of its clients and their caregivers were not easy to work with. It became apparent that this "lack of full cooperation" may be considered indicative of "complex case management" requiring the highest level of clinical skills, patience and perseverance. It still is not clear at what point lack of cooperation should be grounds for termination. Guidelines will be forthcoming based on the experiences encountered over the course of this Project's demonstration period.

There is a concern regarding the identification of its target group. One of the criticisms that has been raised regarding traditional Medicare reimbursed home-health-care services is its inability to provide long-term continuity of care. Continuity of care by a case manager represents an important method to assure linkages with health-care professionals and access when a change of client status is identified. The Project has assumed the responsibility of providing long-term continuity of care with case management for the duration of the Project as long as it is deemed beneficial to the client. However, long-term management may not be cost-effective unless it is well targeted to the most frail and to those at greatest risk for institutional care. The Project's eligibility criteria has been refined as the Project has gained more understanding of Hawaii's uninsured and underinsured concerns.

The Project has been providing client services using 3 service delivery strategies as discussed earlier. Assuming that cost-effectiveness will have been demonstrated, an evaluation

FIGURE 9
COMPARISON OF MAJOR COMMUNITY CASE MANAGEMENT PROGRAMS
OAHU 1990

PROGRAM	ASSESSMENT				HHC	PERSONAL	CASE MANAGEMENT		FEE & OTHER COMMENTS
	MED	RN	SW	OTHER		CARE	SHORT	LONG	
Maluhia Project	x a	x	x		x	x b		x	Free; Uninsured and Underinsured; demonstration project. Oahu. Age 18 and medical risk, need skilled home care.
Kuakini Geriatric Consult	x	x	x	x			x		Medicare; geriatric assessment; limited intake. Oahu only. Age 60+.
Nursing Home Without Walls		x	x			x		x	Medicaid eligible only; ICF/SNF levels; limited caseload; Statewide. All ages.
Project Malama			x					x	Free; no income criteria; long waitlist; Oahu only. Age 60+. Require 2-3 ADL.
Public Health Nursing		x						x	Free; low income emphasized; limited visits; Statewide (selected areas); large caseloads.
Honolulu Gerontology Program			x				x		Free; crisis & short-term management. Age 60+.
Catholic Charities				x		x c		x	Free; Oahu only, no income criteria. Age 60+.

LEGEND:
a = Physician - consultant only
b= home health aid services available when there is a skilled need
c = Chore, escort, transportation

Note: This comparison chart does not incorporate case management conducted by the Dept. of Health's Mental Health Division, Developmental Disabilities Branch. Electronic Alarm Monitoring Services, Day Centers, etc.

of the 3 service delivery strategies will provide additional clues regarding the most appropriate means of delivering services to the uninsured and underinsured.

Referrals and admissions have been slow but steady and appropriateness has improved with further outreach to referral sources. As of April 1991, for example, the Project's census has exceeded 115 cases. Linkages have been made with Hawaii's SHIP program to provide home care to those who need it since SHIP does not include home health care. The Project also is expanding its services to Hawaii County by summer 1991 and to the other neighbor islands at a later time.

The Project foresees the need for closer collaboration with the medical community for appropriate referrals and medical care. While the Project staff already coordinates the clients' plan of care with attending physicians, it may be that home visits by physicians may be instrumental in preventing or postponing hospitalization or long-term care institutional placement in some cases.

Conclusion

This report represents an initial attempt to inform the Hawaii medical community of the status of the Maluhia Project: Home Health Care for the Uninsured after one year of service delivery. This demonstration project represents one of Hawaii's first attempts at serving the medically uninsured and underinsured. Together with Hawaii's SHIP that has enrolled nearly 11,000 members to date, the Hawaii State Department of Health is moving toward the development of a comprehensive health service plan for all.

Federal reauthorization of this national demonstration project as exemplified in the recently enacted Home Health Care Demonstration Projects Extension Act of 1990 signifies support until September 1994. It is hoped that this extension will provide sufficient time to build up the referral and enrollment rate so as to identify the needs and target groups who benefit most from these expanded services. The Project will collect data on the identified uninsured and underinsured to facilitate improved access for their health care. It also will assess the programs cost-benefit ratios and thereby propose a means for continuation of the program if that is appropriate. The participation of the medical community in identifying and referring cases will be a critical link in ensuring that services are rendered to those who are the highest risk and will assist in helping the Project demonstrate a continued need for such services.

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